TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STRATUS ANESTHESIA ASSOCIATES OF DALLAS

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-17-1011-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier has issued a payment for our service but not the correct allowable per the 2016 Texas Workers Compensation fee schedule."

Amount in Dispute: $643.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2016	Anesthesia Services CPT Code 01480-QX (58 minutes)	$643.77	$36.93

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the recommended payment for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment for the disputed anesthesia services with claim adjustment reason code P12 – "Workers compensation jurisdictional fee schedule adjustment." Only the amount of the fee is in dispute; therefore, the disputed services will be reviewed for payment in accordance with applicable division rules and fee guidelines.

   The disputed services are professional medical services involving administration of anesthesia which is subject to reimbursement according to the division's professional services fee guideline, 28 Texas Administrative Code §134.203.

   Rule §134.203(c)(1) requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories . . . Anesthesia . . . the established conversion factor to be applied is $52.83. . . .
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of anesthesia base units and the anesthesia time units (the documented time in minutes divided by 15 and rounded to the nearest decimal) multiplied by a conversion factor. The MAR is calculated by substituting the division's conversion factor. The applicable division conversion factor for anesthesia in calendar year 2016 is $56.82.

   Reimbursement is calculated as follows:

   The number of anesthesia base units for procedure code 01480 is: 3

   The documented time of 58 minutes, divided by 15 and rounded to the nearest decimal is: 3.9

   The sum of the time units and anesthesia base units is: 6.9

   This amount multiplied by the division conversion factor of $56.82 is: $392.06

   Additionally, the provider billed the service with modifier QX, indicating a medically directed procedure subject to 50% payment reduction, for a total reimbursement of: $196.03

2. The total allowable reimbursement for the services in dispute is $196.03.
   The insurance carrier has previously paid $159.10.
   The requestor is entitled to additional payment of $36.93.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the amended findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

This **amended** findings and decision supersedes all previous decisions rendered in this medical fee dispute.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $36.93.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. This **amended** order supersedes all previous orders issued in this medical fee dispute. Pursuant to a grant of authority by the Commissioner of Workers' Compensation to issue, amend or withdraw medical fee dispute resolution findings, decisions and orders, the respondent is hereby ORDERED to remit to the requestor the amount of $36.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	January 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.